Abbey Nursing & Care Agency Limited

Abbey Nursing & Care Agency

Inspection report

109 Washway Road
Sale
Greater Manchester
M33 7TY

Tel: 01619732066
Website: www.abbeynursingandcareagency.co.uk

Date of inspection visit:
28 February 2018
01 March 2018
05 March 2018
07 March 2018

Date of publication:
04 October 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 28 February, 1, 5, 7 and 9 March 2018 and was announced. The service was last inspected in October 2016 and was rated 'Good' overall.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to older adults, younger disabled adults and children. At the time of this inspection the service was supporting 52 people.

Not everyone using Abbey Nursing and Care receives regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a manager in post who had been registered with CQC since October 2010. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found six breaches of the Health and Social Care Act (HSCA) regulations in relation to recruitment processes, safe care and treatment, effective safeguarding systems, staffing training, managing complaints and good governance. We found one breach of the Care Quality Commission (Registration) Regulation 2009 in relation to notifications of incidents. In light of the concerns we found at this inspection, we asked the registered provider to enter into a voluntary agreement with the CQC, to which they agreed, to suspend new packages of care until the service was compliant with all regulations.

We made a recommendation that the registered provider review current good practice such as National Institute for Health and Care Excellence (NICE) guidelines in relation to the safe disposal of medicines in the care at home sector.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what other action we have told the provider to take at the back of the full version of the report.

We found the service was not safe. People we spoke with raised concerns that care visits were not on time and especially at the weekend. Some people had experienced missed visits which had resulted in missed medication. This meant people were not receiving care and support at times which suited their needs. Following these missed visits, a system for managing these had been implemented. However the registered manager was unable to demonstrate that the current system was effective. This meant people were still at risk of experiencing missed visits as there was no effective means of preventing these.

Recruitment processes were not robust. This was a breach of the regulations and meant people were not protected from risk of unsuitable staff being employed.

Risk assessments were not always up to date and risks to some people had not been assessed and recorded. This meant staff did not have sufficient information to ensure people were supported people safely.

Staff we spoke with were able to describe the types of abuse and what action they would take if they suspected abuse was taking place. Recent safeguarding incidents had been reported to the local authority. The registered manager had not always notified CQC about these incidents as required by law. This was a breach of the regulation regarding notifiable incidents which registered providers must follow.

The registered provider did not have adequate oversight of staff training and development since we found the current induction and training systems did not provide suitable assurances that all staff had the required skills and competencies to carry out their roles effectively. This was a breach of the regulation relating to staffing and meant people were at risk of harm.

Care records contained initial assessments, person centred information about how people were to be supported and risk assessments. Records included appropriate equality and diversity information. We saw that reviews were currently being carried out. But no action plan had been devised to address concerns raised during these reviews.

People said staff's approach was caring and that staff carried out their duties in a respectful manner. Staff supported people with dignity and encouraged them to maintain their independence according to their abilities. We found however the registered provider did not demonstrate the hallmarks of a caring organisation as they had not ensured staff had received the right training and support to care for people in a safe and person centred way.

The registered provider did not demonstrate there was an effective system of managing complaints and concerns raised about the standard of care provided. Some people told us they would contact the office to raise a concern but not everyone was aware of the registered provider's complaints procedure.

We found the quality assurance framework was not sufficiently robust and did not give the registered manager and registered provider effective oversight of the quality and safety of service. This meant people's care and support was not adequately monitored to ensure their safety and wellbeing.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Recruitment processes were not sufficiently robust and did not provide assurances that suitable care staff were employed.

Some people had experienced missed or late visits from care staff. The provider did not carry out or record how safeguarding incidents had been investigated.

Risks to people were not always considered so there was no guidance in place to help staff support people in a safe manner.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received an adequate induction or suitable training to have the relevant skills and competencies required to perform effectively in their roles.

The service was working in line with the Mental Capacity Act. There were systems in place to assess people's mental capacity and monitor for change.

People were supported, where assessed, to maintain healthy nutrition and hydration, and supported to access health care professionals as required.

Is the service caring?

Requires Improvement

The service was caring.

People and their relatives said staff were kind and that they were happy with their support. However the registered provider had not ensured staff were appropriately trained and supported to provide compassionate and person-centred care.

Staff treated people with dignity and respect and encouraged people to maintain their independence according to their ability.

Care records demonstrated that people's equality and diversity needs had been considered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Support plans were person centred and contained a holistic assessment of people's needs. This included personal histories, communication needs and equality and diversity information. Though care plans had been reviewed not every aspect of them had been updated to reflect people's current needs.

Not everyone we spoke with knew about the service's complaints procedure. The registered manager did not provide evidence that there was an effective complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider did not have an adequate overview of the quality of the service because systematic quality assurance processes were not carried out. A new quality tool to audit care records in people's homes had been recently implemented and staff spot checks had resumed recently.

Not all notifiable incidents had been reported to the Care Quality Commission as required by law.

The registered provider had not sought people's feedback or their views on the service they received since 2016.

Abbey Nursing & Care Agency

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was brought forward following information of concern received from the local authority and whistle-blowers relating to poor recruitment practices, missed visits and untrained staff.

This inspection took place on 28 February and 1, 5, 7 and 9 March 2018 and was announced. This inspection was originally scheduled to be unannounced however when we arrived on 27 February 2018, the offices were closed and there was no one to receive us at that time. We called the office number and spoke with the care manager. We made arrangements to return to their offices on the following day. Our inspection site visit activity started on 28 February 2018 and ended on 9 March 2018. It included the office site visit, telephone calls to people and their relatives and visits to people's homes.

The inspection team consisted of one inspector, an assistant inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this occasion the expert-by-experience had experience in older people services.

As this inspection was brought forward, the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service such as notifications. A notification is information about important events which the service is required to send us by law. Prior to our inspection, we spoke with the commissioners at Trafford local authority who provided information on their current monitoring of the

service which included missed visits and reviewing people's care packages. We also contacted Trafford Healthwatch and checked their website. Healthwatch had not received any feedback about this service to date. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services.

With their prior consent, we visited one person in their home and we spoke with one person and three relatives by telephone over a series of days as people did not answer their telephones. During our visit to the offices, we spoke with the registered manager, the care manager, two care coordinators and one care assistant. We looked at records relating to the service including four care records, four staff recruitment files and staff training documents, and operational policies and procedures.

Inadequate

Is the service safe?

Our findings

We found recruitment processes were not sufficiently robust to ensure suitable staff were employed to work with vulnerable people. We looked at four staff recruitment files and identified the following concerns. Two staff members had not provided any education/training information; three staff members had unexplained gaps in their employment history. We looked at interview records and found these gaps in education and employment history had not been investigated or discussed. We saw two staff members had not provided references from their most recent employer and where the registered manager had been unsuccessful in collecting references, we found no evidence they had attempted to seek a suitable alternative reference. We found two staff members did not have records on file to confirm that appropriate disclosure and barring service (DBS) checks had been carried out. The DBS keeps a record of criminal convictions and cautions which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups.

One staff member had indicated on their application form that they had a caution or conviction but we found no record that this offence had been discussed at interview. Their file contained a copy of the header section of their DBS certificate requested by their previous employer but did not contain the rest of the document which would have included the details of the caution or conviction indicated on their application form. Employers can employ people who have had previous conviction if they satisfy themselves the prospective staff member does not pose a risk to the people they would be supporting. We found that no risk assessment had been completed to ensure this staff member was suitable for the role of care assistant. These concerns were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and meant people were at risk because safe recruitment practices were not in place.

We looked at how risks relating to people's care were assessed and managed. We found risk assessments for moving and handling tasks, medicines and the home environment in place. Risk assessments should provide clear and person-specific guidance to staff and ensure that control measures are in place to manage the risks an individual may be exposed to. In one person's care records dated January 2018, it stated they spent most of their time in bed and part of their planned outcome was to "prevent pressure sores". This person's care plan also stated they were fitted with a catheter. Therefore, we would expect to see risk assessments relating to pressure areas and catheter care. We found no risk assessments were in place in relation to the support required to reduce the risk of pressure sores developing and catheter care. In a protection plan dated 17 February 2018 requested by Trafford local authority as a result of a late visit, we found the risk of pressure sores developing had been identified. However the person's care plan had not been updated to provide guidance to staff to mitigate the identified risk. This meant the person was not protected from harm because the service had not considered the potential risk and staff did not have clear guidance to help them support the person safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with said staff administered their medicines safely. We spoke with two members of staff about administering medicines and we found they supported people to take their medicines safely. We identified concerns however with how staff told us they disposed of medicines when people refused them.

Staff told us they recorded that the medicines had been refused and then disposed of the medicines in the outside bin. We checked the provider's medication disposal policy and found the way in which staff disposed of medicines contradicted what was in the policy. We highlighted this to the registered manager who told us their contract with the local authority did not fund the disposal of people's medicines and that people were responsible for disposing of their own medicines. We made a recommendation that the registered provider review current good practice such as National Institute for Health and Care Excellence (NICE) guidelines.

Most people and relatives we spoke with also confirmed that staff were sometimes late. One relative said, "Carers only come at the weekend. They (staff) have been up to an hour late a few times." Prior to our inspection we had received information of concern from the local authority and a whistleblower about late and missed visits. We also reviewed safeguarding information we had received from the local authority previously. On the first day of our inspection we asked the care manager for a record of calls that had been missed since our last inspection in October 2016. They showed us a record of four safeguarding incidents which only included two missed calls from November 2017 to February 2018. This record did not contain information we had gathered previously from the local authority nor did it contain the most recent incidents of missed and late calls and missed medicines that had occurred in February 2018.

We asked the care manager and the registered manager what measures were in place to prevent calls being missed or late. They told us staff had to contact the office when they had started their rounds. The office staff would the record that the shift had started. We asked to see a copy of these records however we were told they had not been kept. We asked the care manager if staff called at the start and end of each call visit or shift. They told us staff only called at the beginning of their shift. This meant people were still at risk of missed or late calls because the system did not effectively monitor whether all other calls were on time. People were at risk of harm because they did not receive care and support as required and documented in their care plan. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see how incidents including safeguarding had been investigated. The care manager told us incidents were recorded on a summary log and kept in people's care files. They said staff who had been involved in any safeguarding incident were disciplined according to the registered provider's policy. We looked at how the most recent incidents in February 2018 had been managed. We reviewed two people's care records and found safeguarding referrals. When we checked staff records relating these incidents there was no evidence that disciplinary meetings had taken place.

We found the safeguarding log was not kept up to date and did not record the most recent incidents of missed calls which resulted in missed medicines for some people, late calls and theft. We asked the care manager whose responsibility it was to update this record but they could not answer our question. This meant the registered provider had no systematic way of knowing the number of incidents, including safeguarding, that had occurred and if any of these were preventable. We also found no evidence the registered manager had carried their own internal investigation into incidents and safeguarding, as appropriate. We were not assured that the registered provider had an effective system in place to record and investigate safeguarding incidents. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us, in the main, they knew the staff who provided care and support and that staffing levels were as needed. They said they had some concerns about the number of staff changes that had taken place in recent months. We spoke with the care manager and the registered manager about these changes and how it affected the care provided. They told us the previous care manager and some care staff

had left the service however they had recruited a new care manager and new care staff. People's comments included: "I have two particular carers who know my needs very well. I have developed a rapport with them", "There have been some staff changes recently but the new carers seem very nice. A new carer comes with a carer we know and "I would like to be informed if new carers are scheduled to complete my care." One person told us that on some occasions, especially on weekends, only one staff member had attended their visit. They told us according to their care plan (which we confirmed), they required two staff members at all times to support them safely. They told us they had raised this issue with the registered manager and that it had been resolved.

Staff we spoke with could explain the different types of abuse people may face and what action to take if they suspected abuse was taking place. However training records showed not all staff had received training in safeguarding vulnerable adults when they started working at the service. People and relatives we spoke with said they or their family members felt safe in the care of staff, including feeling safe from any form of abuse or intimidation. They told us they would ring the office if they felt unsafe or unhappy in any way with a staff member. One relative said, "I feel the care my husband receives is safe and when I have raised a concern about (their) care or the timing of visits things have been resolved very quickly. When I have raised concerns the manager and staff have been very prompt to respond."

People and relatives told us staff always wore personal protective equipment (PPE) such as gloves as required. Staff we spoke with told us how they used PPE to keep people safe. We concluded staff kept people safe by demonstrating responsibility in promoting effective infection control and prevention.

Inadequate

Is the service effective?

Our findings

We found the current induction and training systems in place did not provide suitable assurances that all staff had the required skills and competencies to carry out their roles effectively. We found the registered provider did not have adequate oversight of staff training and development. For example, in two staff files we looked at we saw an induction training plan however other staff files we viewed did not have records to show they had completed the induction plan. We found evidence that staff had not done any training considered mandatory by the provider. We found examples of staff completing competency checks such as for medication administration and percutaneous endoscopic gastrostomy (PEG) feeding without having done the relevant training. On day two of our inspection, the care manager provided us with a list for each staff member which identified what mandatory training required updating. We found more than 50 percent of the staff had either not yet started or completed these mandatory updates such as safeguarding, medication practical assessment and moving and handling. One person told us they had been supported by staff who were not trained in how to use hoist. We found the provider supported people with PEG feeding, catheter care, and people living with dementia yet we found no evidence of how the provider ensured staff were competent to support people with these identified needs effectively. The care manager and the registered manager told us they were in the process of having PEG feeding carried out. On 5 March, 2018, the registered manager showed us an email of the same date requesting this training. This meant staff had been supporting people with their PEG without receiving training in how to do so safely.

We asked to see records of staff supervision and appraisals carried out since our last inspection in October 2016. These were not available. The care manager told us they had not had supervision since starting this new role in October/November 2017. Staff we spoke with including the care manager said they felt supported by the registered manager and they could speak with them at any time if needed. However based on the evidence we found at this inspection the registered provider did not sufficiently demonstrate that staff were effectively equipped and supported to carry out their roles. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our site visit, the registered manager told us they were in the process of ensuring all staff completed their mandatory training, had a supervision and, where relevant, an appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For a domiciliary care agency, it would be under an order from the Court of Protection. No one supported by Abbey Care and Nursing Agency was subject to a court of protection order.

We looked at four care records and found consent to care had been appropriately sought. People and their relatives told us staff always sought consent prior to carrying out any task. One person told us, "The carers are good. They chat to me throughout, checking I am OK with everything." Staff we spoke with had an understanding of the MCA and their role in ensuring the rights of the people they supported were safeguarded. We found the provider had processes in place to assess and record people's mental capacity. We were satisfied the provider was following the MCA principles to help ensure people's rights were safeguarded.

Care records we reviewed showed the registered manager carried out an initial assessment upon which a person's care plan was based. We found care plans contained detailed information about the person's assessed needs and an equality and diversity profile. Staff we spoke with said this information helped them to understand the needs of the person. People we spoke with confirmed this. One person said, "I have two particular carers who know my needs very well. We have developed a rapport with them." A relative told us, "The majority of staff have a clear knowledge and understanding of my (relative's) needs and provide good care for him."

Care records confirmed staff liaised with healthcare professionals such as district nurses and GPs, as required. One person told us the registered manager was "good at sorting things out" to ensure they received the right medical attention when needed. One staff told us a person had been repeatedly refusing to take their medication. We found staff took appropriate action to ensure the person's health was not comprised as a result. This meant staff were proactive in ensuring people's healthcare needs were managed effectively.

Where assessed as a need, we found staff supported people with meals and drinks. No one we spoke with raised any concerns in this area and they told us staff supported them or their relative as identified in their care plan to maintain their nutritional and hydration needs.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives told us staff were caring. One person said, "All the carers I have had from this provider are kind and treat me with respect." A relative told us, "The staff are all caring and kind. They chat with [person] and listen to both of us. They help [person] to remain at home."

Staff we spoke with knew the people they supported and were able to tell us people's preferences, their support needs and how they preferred to be supported. People and relatives we spoke with confirmed this. One relative told us they found the staff to be friendly and "seems to know my [relative] well." We looked at the care records for two people and we found what staff had told us about the people they supported such as favourite foods, daily routines and interests reflected in the care plans. This meant staff had relevant information to be able to build relationships with the people they supported.

Although people and their relatives were positive about their interactions with staff at Abbey Care & Nursing Agency, we found the registered provider did not give staff the training and support they needed to provide care and support in a compassionate and person-centred way. As reported in the Effective domain of this report, we found a number of staff had not completed key training in areas such as medication training, moving and handling and safeguarding nor had the registered provider considered additional training relevant to the needs of people supported such as dementia awareness and catheter care. This meant some members of the staff team were not fully equipped to provide personalised care to people with these conditions because they had not received the necessary training. We found these concerns did not demonstrate the hallmark of a caring organisation.

People and their relatives said the service had provided appropriate information regarding the care and support provided. One person said, "I have been involved in my care plan." People and their relatives told us and the care records we looked at confirmed the service carried out an initial assessment prior to providing care. People and relatives told us they felt the service listened to and dealt with any concerns they raised appropriately. They said if they had any concerns about their care they would telephone the office to discuss them. Everyone we spoke with said the registered manager was very accommodating and that both the registered manager and staff were approachable. We concluded people and relatives felt included and were consulted in making decisions about the care they received.

Abbey Nursing and Care worked within a diverse and multicultural community. We saw that the registered provider had appropriate policies and procedures to help ensure staff understood how to protect people's rights and to challenge discrimination. We found care plans recorded relevant information regarding people's ethnicity, religious and cultural beliefs and practices.

People and their relatives said they were respected and treated in a dignified manner. They told us all care staff covered them appropriately when undertaking personal care tasks. One person told us, "All the carers I have had from this provider are kind and treat me with respect. They listen to my needs. They respect my dignity and privacy and they help me to remain at home."

People told us staff encouraged them to undertake tasks independently but was there to provide help and reassurance as needed. One person told us, "(Staff) are very good about encouraging me to be independent for example when using the walking frame." Another person said staff supported and encouraged them to do exercises to maintain their mobility.

We found confidential information relating to people supported and staff personnel were stored appropriately in the office and only accessed by staff authorised to do so.

Requires Improvement

Is the service responsive?

Our findings

We found care records for the most part contained person centred information about how people were to be supported and included appropriate equality and diversity information, communication needs and impairments such as hearing loss. People and their relatives told us and care records showed they had been involved with planning their care. One person said, "The manager came to my home and went through my care plan." Another person told us, "I am very much involved in the care I need."

During our inspection, we noted the registered manager had been asked by the local authority to carry out reviews of all packages of care commissioned by the local authority to ensure the care and support provided was still appropriate. During our inspection we saw nine reviews that had been carried out in February 2018. We noted concerns on these review documents had been raised but no action plan had been developed to address these. In one person's records dated 28 January 2018 indicated their risk assessment need to be updated because of changes in moving and handling equipment. However at the time of this inspection in March 2018, this had not been done. On another person's review document dated 19 February 2018 it stated they were not happy with late and missed calls and wanted to be notified when carers were going to be late. This meant people's needs were not managed in a proactively to ensure the service was responsive to their needs.

We looked at how the service managed complaints and concerns and whether the registered provider had communicated to people how they could raise concerns. We found that the complaints process was ineffective. One the first day of our inspection, the care manager told us complaints procedures were currently being put into the care files in people's homes. One person we spoke with confirmed this. They said the complaints policy had been put into their care file the previous evening after the service knew CQC would be visiting their offices the following day. This person told us however they knew who to contact if they had issues or concerns. A relative told us they were not aware of a complaints procedure but would go into the office and speak with the registered manager if they had a complaint. We found the service user guide did not contain specific information about the registered provider's complaints process and we highlighted this to the registered manager. However most people and their relatives told us they were confident the service would listen to and act upon their concerns.

Prior to this inspection we received information of concern from a member of the public in December 2017 about staff performance and timekeeping. We asked the registered manager to investigate these concerns and provide a response to us. Their response at that time did not specify what action had been taken to resolve the concerns. At our inspection, we asked the registered manager to see how this concern and others such as missed visits and timekeeping had been managed. The registered manager provided no information to demonstrate that concerns were taken seriously and investigated. They told us some of these concerns had been dealt with verbally and therefore no record of outcomes had been kept. The registered provider failed to demonstrate there was an effective complaints procedure in place which investigated concerns and ensured necessary action was taken in response. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post since October 2010 and they were supported in the operation of the care provision by a care manager and two care coordinators.

People and their relatives told us about their concerns regarding a number of staff changes that had taken place in recent months (from November 2017 to present day and discussed in the Safe domain) and sometimes having difficulty in contacting the office. However everyone we spoke with told us the registered manager and staff were approachable and they were happy with the service they received. Comments included: "Overall I would like to say I am very happy with the service. This is the fifth agency I have used and this is the best", "I have spoken to the manager and staff about any concerns we have had but overall we are very happy with the service" and "I have gone into the office a few times to pay for my mother's care and everything seems well run and organised."

In light of the severe weather warnings the region experienced during this inspection, we asked the care manager about their contingency plans that would help ensure people's care and support were not adversely affected. They were not aware of any contingency plans and told us the registered manager dealt with these. We pointed out to the care manager that the registered manager was not in office and therefore they should have some sort of plan to manage any issues that may come up, for example, people who were most vulnerable and depended completely on the support of Abbey Nursing and Care Agency. The care manager assured us that staff knew who the most vulnerable people were but that this information was not recorded. This meant people may be at risk because there was no specific and systematic information in place to guide staff during emergencies such as poor weather.

We checked to see what quality monitoring processes were in place to help ensure the registered provider and registered manager had an overview of the quality of the service provided. We found the last user satisfaction survey had been done in June 2016. We asked if people's views about the service had been sought in 2017. The registered manager told us they had not but that they would be doing one in 2018.

At this inspection, the care manager and the care coordinator told us they were using a new quality tool to audit care records in people's homes. This audit tool had been recently devised following the local authority's suspension of their services and subsequent monitoring visit. We found that staff spot checks had been resumed in January 2018. We found not all staff employed since our last inspection had had a spot check. We asked the registered manager and the care manager what other audits were in place such as for daily records and medication administration records. The care manager told us they intended to audit daily records but that this process had not started yet.

We found the registered provider's governance and oversight of the service to be ineffective and therefore had not identified the concerns we found such as inadequate recruitment processes, missed and late visits and no effective system for managing these, the lack of staff training and competency checks, no evidence of the process for safeguarding investigations, the lack of oversight of accidents and incidents that had occurred and the lack of an effective complaints process.

Based on the evidence provided or lack thereof we found the registered provider and registered manager did not have a consistent and continuous overview of the quality of the service to help ensure people received care and support that was of a satisfactory standard. Failure to do so was a breach of Regulation 17(1) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Following our site visit the registered manager sent us their plan of action to address the concerns we raised during our inspection.

We found the registered manager did not always report notifiable incidents to the Care Quality Commission (CQC). We found five safeguarding incidents that occurred between March 2017 and February 2018 that the service had not notified us about. Failure to report notifiable incidents such as safeguarding was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We asked to see the minutes of staff meetings held since we last inspected the service in October 2016. The care manager told us there had not been any general staff meetings for some time but that one had been scheduled for the following week. This meant staff did not have an appropriate forum in which to discuss work-related issues and receive support from their manager and peers to help them function effectively in their role.

The care manager provided us with minutes of meetings of the senior management team in October 2017, January 2018 and February 2018. These records showed discussion had taken place regarding care record documentation, rotas, auditing care plans and staffing. We asked if and how this information had been communicated with the rest of the staff. The care manager showed us an emailed memo that had gone out to all staff regarding care documentation. We pointed out however there were other issues that had been discussed which were relevant to all staff such as the reporting of incidents, and the registered manager was unable demonstrate to us that these issues had been communicated with the rest of the staff team. They told us they intended to discuss these topics at the upcoming meeting.

During our inspection, we checked the provider's website and at their offices to ensure they conspicuously displayed their most recent rating. We found they did so as required by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager did not always report notifiable incidents to the Care Quality Commission as required by the law. Reg 18

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm because they did not receive care and support as required and documented in their care plan Reg 12(1) People were at risk of harm because risks to them had not been considered and appropriate action put in place to ensure staff had sufficient information to support them safely. Reg12(1)(2)(b)(c)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of harm because the registered provider did not ensure systems and processes were established and functioned effectively investigate and prevent abuse.

Regulated activity	Regulation

Personal care

Treatment of disease, disorder or injury

Regulation 16 HSCA RA Regulations 2014
Receiving and acting on complaints

The registered provider failed to demonstrate there was an effective complaints procedure in place which investigated concerns and ensured necessary action was taken in response.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems did not provide effective and adequate oversight of the service's operations nor did they monitor that quality of care and support provided was of a satisfactory standard.

The enforcement action we took:

Served WN

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider did not carry out appropriate pre-employment checks and where relevant did not thoroughly risk assess candidates to help ensure people were supported by suitable staff.

The enforcement action we took:

Served WN

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider put people at risk of harm because they did not sufficiently demonstrate that staff were effectively equipped and supported to carry out their roles.

The enforcement action we took:

Served W\N